

FILED JUN 6 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18497

Registration District No. 601

Primary Registration District No. 5796

Registrar's No. 4

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Florence, Mo., R.F.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County Morgan

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Emma Ligetta Sanders

8. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

20. DATE OF DEATH: Month May day 2 year 1941 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from June 17, 1939, to May 2, 1941; that I last saw her alive on May 1, 1941 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry Sanders 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Aug. 14 - 1887
(Month) (Day) (Year)

Immediate cause of death Carcinoma of left kidney and descended colon / 2 yrs.

8. AGE: Years 53 Months 8 Days 19 If less than one day hr. _____ min. _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Morgan County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name John Brunkhorst

18. Birthplace Hanover, Germany
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Cordes

15. Birthplace Morgan County, Mo.
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

5-29 (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Chas. D. Osborne (M. D. or other) _____

Address Florence, Mo. Date signed 5/3/41

16. (a) Informant Carrie Ann Sanders

(b) Address Florence, Mo. - R.F.D.

17. (a) Burial (b) Date thereof 5-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Parker Funeral Home

(b) Address Otterville, Mo.

19. (a) May 4 1941 (b) Mr. Arthur Schuler
(Date received local registrar) (Registrar's signature)

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RECEIVED

District Health Officer No. 7,

District File Number 6-41-902

Date Filed 6-4-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

myself....., Registered Apprentice No.....
working under my personal supervision.

Signed Lucius F. Parker TEVA

Licensed Embalmer No. 3840

P. O. Address Otterville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18497

Registration District No. 601

Primary Registration District No. 5796

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Ridgeland T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Emma Lizzetta Sanders

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>8</u>	<u>19</u>	hrs. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of left kidney and descending colon
Due to Coloyp

Due to Carcinoma of Left Kidney primary with extension involving descending colon
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations #6520
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-18497 1941